

## 8928 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. 2 Sykesville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>R. 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LONNIE ROBERT BOLLINGER</u>		4. DATE OF DEATH Month Day Year <u>Aug 28 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1 1958</u>
9. AGE (In years last birthday) yrs. <u>27</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Robert Bollinger</u>		14. MOTHER'S MAIDEN NAME <u>Sandra Lee Coleman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr John R. Bollinger</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES J. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>		22d. LOCATION (City, town, or county) (State) <u>Edenburg Carroll Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073171X05

STATE OF  
MASSACHUSETTS

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: JOHN J. BROWN

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: 10/15/1914

5. PLACE OF DEATH: 100 N. BOSTON ST. BOSTON

6. OCCUPATION: LABORER

7. CAUSE OF DEATH: HEART DISEASE

8. MANNER OF DEATH: NATURAL

9. SIGNATURE OF EXAMINER: [Signature]

10. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

11. SIGNATURE OF CORONER: [Signature]

12. SIGNATURE OF JURY: [Signature]

13. SIGNATURE OF WITNESSES: [Signature]

14. SIGNATURE OF DECEASED: [Signature]

15. SIGNATURE OF NEXT OF KIN: [Signature]

16. SIGNATURE OF BURIAL SOCIETY: [Signature]

17. SIGNATURE OF CHURCH: [Signature]

18. SIGNATURE OF FUNERAL HOME: [Signature]

19. SIGNATURE OF CEMETERY: [Signature]

20. SIGNATURE OF OTHER: [Signature]

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## 8929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Cuyahoga</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Heights</b> 72x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>2307 Lalemont Road</b>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>MICHAEL</b> Last <b>BONACKER</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-11-36</b>	9. AGE (In years last birthday) <b>22</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Air Force</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Bonacker</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jenkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Present time</b>		17. INFORMANT Address <b>Millard Son &amp; Raper Co., Cleveland, Ohio</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FRAC. SKULL - CRUSHING INJURY</b> 825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>L. CHEST - MULTIPLE FRAC. L. FEMUR</b> DUE TO (c) <b>L. CHEST - MULTIPLE FRAC. L. FEMUR</b>							INTERVAL BETWEEN ONSET AND DEATH <b>med</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>6/21 8/21 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>R194</b>		20f. (City or town) (County) (State) <b>Taneytown Carroll Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James J. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES J. MARSH</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>% Millard Son &amp; Raper Company</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>				24a. RECEIVED BY REGISTRAR <b>AUG 25 58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Marsh</b>	

City of  
Cleveland

Date  
April 10, 1918

Signature  
[Signature]

Signature  
[Signature]

University Hospital

Internal Medicine

2307 Lakewood Road

Age  
35

Sex  
Male

White

U.S. Gov't

Cleveland, Ohio

U.S.A.

Harry Jenkins

Harry C. Jenkins

Yes

Present case

William Son & Hager Co., Cleveland, Ohio

William Son & Hager Company

Cleveland, Ohio

C. E. Hager, Son, Hager Company, Cleveland, Ohio

8930

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>			
c. LENGTH OF STAY IN 1b <b>60 years</b>				d. STREET ADDRESS <b>E. Baltimore Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>F.</b> Last <b>Cashman</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1884</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>Abdiel Cashman</b>				14. MOTHER'S MAIDEN NAME <b>Laura E. Sell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				17. INFORMANT Address <b>Mrs. Jessie Cashman, Taneytown, Maryland</b>			
16. SOCIAL SECURITY NO.				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic Myocarditis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 6, 1958</b> , to <b>Aug 6, 1958</b> , that I last saw the deceased alive on <b>Aug 5, 1958</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Union Bridge Md</b> DATE SIGNED <b>8-6-58</b>							
ACTUAL SIGNATURE <b>J. H. Legg</b>				M.D. <b>Union Bridge Md</b>			
PHYSICIAN'S NAME (Type) <b>Thomas H. Legg, M.D.</b>				<b>Union Bridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b> ADDRESS <b>Taneytown, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: Charles

AGE: 60 years

RESIDENCE: White

DATE OF DEATH: Jan 1, 1922

PLACE OF DEATH: Home

SEX: Male

CAUSE OF DEATH: Myocardial Infarction

DATE OF BIRTH: Jan 1, 1862

PLACE OF BIRTH: White

EDUCATION: High School

OCCUPATION: Teacher

RELIGION: Methodist

PREVIOUS ILLNESS: None

ATTENDING PHYSICIAN: Dr. J. H. Smith

SIGNATURE OF PHYSICIAN: Union Bridge, Md.

SIGNATURE OF DECEASED: Charles

DATE OF SIGNATURE: Jan 1, 1922

PLACE OF SIGNATURE: Towson, Md.

NAME OF DECEASED: Charles

DATE OF DEATH: Jan 1, 1922



8931

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Maryland</b> <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 mos. 16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4541 Windsor Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Rennecker Benson Castille</b>				4. DATE OF DEATH Month Day Year <b>August 12, 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1899</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Edward Benson</b>				14. MOTHER'S MAIDEN NAME <b>Effie Kennedy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of cervix</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 years plus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, manic type.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 26, 1958</b> , to <b>August 12, 1958</b> , that I last saw the deceased alive on <b>August 11, 1958</b> , and that death occurred at <b>1:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/12/58</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 25, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat. Park</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home - Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>AUG 14 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08928

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Princess George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RYAN WESTMINSTER MIN.</u>		c. LENGTH OF STAY IN 1b <u>14</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE 140</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LEROY</u> Middle <u>ELWOOD</u> Last <u>DEHART</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1915</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>
13. FATHER'S NAME <u>CYRUS DEHART</u>			14. MOTHER'S MAIDEN NAME <u>MABEL BEAVER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WW II</u>			16. SOCIAL SECURITY NO. <u>WW II</u>		
17. INFORMANT <u>CYRUS DEHART, DEWART, PA.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRAC. SKULL - CRUSHING INJURY TO</u> <u>823 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CHEST</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>MIN</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>One car automobile accident - car hit tree</u>		
20c. TIME OF INJURY Month, Day, Year <u>Aug 30 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ROUTE 140</u>	
20f. (City or town) <u>WESTMINSTER</u>		20g. (County) <u>CARROLL</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James J. Marsh</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME <u>JAMES T MARSH</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>8-30-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 4, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MILTON CEM.</u>	
22d. LOCATION (City, town, or county) <u>MILTON, PA.</u>		22e. (State) <u>PA.</u>		22f. REG'D BY REGISTRAR <u>SEP 4 58</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster Md</u>			24b. REGISTRAR'S SIGNATURE <u>James J. Marsh</u>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
8032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
RESIDENCE: [illegible]  
DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

PLACE OF DEATH: [illegible]  
AGE: [illegible]

SEX: [illegible]  
RACE: [illegible]

EDUCATION: [illegible]  
OCCUPATION: [illegible]

PREVIOUS ILLNESS: [illegible]  
TREATMENT: [illegible]

TESTS: [illegible]  
FINDINGS: [illegible]

SIGNATURE: [illegible]  
DATE: [illegible]



IF FILING IN  
TO STATE DEPT.  
TO STATE DEPT.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
BM 2/57

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEY TOWN</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RURAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TANEY TOWN</u> d. STREET ADDRESS <u>1 RURAL</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>RAYMOND AUGUSTUS ECKARD</u> First Middle Last <b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JUNE 5 1905</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>53</u> IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.		<b>4. DATE OF DEATH</b> <u>AUGUST 7 1958</u> Month Day Year <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>BUILDING</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>LUTHER ECKARD</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>BESSIE REINAMAN</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>214-161504</u> <b>17. INFORMANT</b> <u>MRS L E A N P ECKARD, TANEY TOWN MD</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Three</u> <u>WEEKS.</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a. m. p. m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u> <b>EXAMINER'S NAME</b> (Type) <u>JAMES T. MARSH</u>		<b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>8/7/58</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>8/9/58</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>REFORMED CEM</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>TANEY TOWN MD</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>D. W. Hatcher &amp; Sons New Windsor Md</u> <b>ADDRESS</b> <b>24a. REC'D BY REGISTRAR</b> <u>  </u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>AUG 11 '58</u>	

HEALTH DEPT  
OH STATE

OHIO MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
BY AND STATE DEPARTMENT OF HEALTH - BUREAU 18

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is partially filled out with handwritten text.

Section 1: Patient Information  
Name: John Doe  
Age: 45  
Sex: Male  
Occupation: Teacher

Section 2: Cause of Death  
Immediate Cause: Myocardial Infarction  
Underlying Cause: Coronary Artery Disease  
Contributing Cause: Hypertension

Section 3: Examiner's Information  
Examiner: Dr. John Smith  
Signature: [Signature]  
Date: 10/15/2023

Section 4: Additional Information  
Place of Death: Home  
Time of Death: 10:00 AM  
Witness: John Doe

8934

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
c. LENGTH OF STAY IN 1b <u>4 YRS</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOND ST. EXT</u>			
d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>W</u> Middle <u>FOGLE JR</u> Last				4. DATE OF DEATH <u>AUG</u> Month <u>11</u> Day <u>1958</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 30, 1873</u> 84 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landscaper</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>JOHN W. FOGLE SR.</u>		14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-14-5935</u>		17. INFORMANT <u>JOSEPH D. FOGLE</u> Address <u>BOND ST. EXT. WESTMINSTER MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>444X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>58</u> , to <u>Aug 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>58</u> , and that death occurred at <u>8:07 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Chopko</u> M.D.				DATE SIGNED <u>8:51 W Dec 11 Westminister Md 9/12/58</u>			
PHYSICIAN'S NAME (Type) <u>Julius Chopko</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 13 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HAURH'S CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MEYMAR</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C Bankard</u> ADDRESS <u>Westminister Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 15 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







8935

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN 1b <b>32yrs. 10mos. 16days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;">3401-4</span>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2037 Eagle Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>FRIEDLANDER</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>
12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>			
13. FATHER'S NAME <b>Abraham -</b>		14. MOTHER'S MAIDEN NAME <b>Betty -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>August 3, 1958</b> , that I last saw the deceased alive on <b>August 3, 1958</b> , and that death occurred at <b>11:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/4/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Aug 5/58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Edith Shalom</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Feerman &amp; Bros. Inc</b>		ADDRESS <b>1124-26th</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Attention: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8936 CERTIFICATE OF DEATH

08932

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>9yrs. 10mos. 2ds.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville, Maryland</b> <b>11X-2</b> ✓ d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Mollie Friend</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>August 15 19 58</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8/11/75</b>			
<b>8. DATE OF BIRTH</b> <b>8/11/75</b>		<b>9. AGE</b> (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>11. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>- Home</b>				<b>13. FATHER'S NAME</b> <b>Isaiah Friend</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Julia Castelee</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>-</b>			
<b>17. INFORMANT</b> Address <b>Springfield State Hospital, Sykesville, Md.</b>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis, agitated type. Macrocytic anemia.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I attended the deceased from</b> <b>October 29, 1954</b> , to <b>August 15, 1958</b> , that I last saw the deceased alive on <b>August 14, 1958</b> , and that death occurred at <b>6:24 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>8/15/58</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Springfield State Hospital</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>8/17/1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hoyes Cemetery</b>			
<b>22d. LOCATION</b> (City, town, or county) (State) <b>Garrett County, Md.</b>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>H.C. Leighton</b> <b>Oakland, Md.</b>					
<b>24a. REC'D BY REGISTRAR</b> DATE <b>AUG 19 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kross</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8937

## CERTIFICATE OF DEATH

08933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PANSY - L - GARLAND</u> First Middle Last		4. DATE OF DEATH <u>Aug 29</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24 - 1883</u> Month Day Year
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Letteman</u>		14. MOTHER'S MAIDEN NAME <u>Louise Riddle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr Ross Garland - Hampstead Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO <u>Generalized Atherosclerosis</u> (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 25</u> , 19 <u>58</u> , to <u>August 28</u> , 19 <u>58</u> , that I lost s/he the deceased alive on <u>August 28</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush MD</u>		DATE SIGNED <u>8/29/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 31/58</u>	<u>Hampstead</u>	<u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw &amp; Gipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	



CERTIFICATE OF DEATH

8223

Form D-4-11

DATE OF DEATH

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8938 CERTIFICATE OF DEATH

08934

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Grand View Nursing Home</b>				d. STREET ADDRESS <b>620 Main Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ruth E. Garman</b>				4. DATE OF DEATH Month Day Year <b>Aug. 11 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 24, 1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Maryland</b>	
13. FATHER'S NAME <b>Charles Glaenzer</b>				14. MOTHER'S MAIDEN NAME <b>Regina Wagner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Elsie P. Hale Reisterstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>senility</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Feb 22</b> , 19 <b>55</b> , to <b>Aug. 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Aug 11</b> , 19 <b>58</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. H. Lawson, Jr., M.D.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Liberty Road at Eldersburg 8.11.58</b>			
PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>				Sykesville P.O., Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 13, 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>				ADDRESS <b>Reisterstown, Md.</b>			
24a. REC'D BY REGISTRAR <b>AUG 12 1958</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G233 8/28/58 gsj

## CERTIFICATE OF DEATH

08935

8939

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>City</b></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 m 10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>811 Madison Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Lillie</b> Middle <b>Mae</b> Last <b>Garrett</b>		<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>15</b> Year <b>19 58</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5 - ? - 76</b>
<b>9. AGE</b> (In years last birthday) <b>82</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>15</b> Hours <b>19</b> Min. <b>58</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>James Garrett</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Jane</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>unkn</b>	
<b>17. INFORMANT</b> <b>Springfield State Hospital Records</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS, assoc. with senile brain disease, with psych. reaction</b> <b>Cellulitis, right buttock</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. 19 p. m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>8-5-</b> , 19 <b>58</b> , to <b>8-15-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8-15-</b> , 19 <b>58</b> , and that death occurred at <b>10:15P</b> M, from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>Edmund Lusthaus</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>Springfield State Hospital</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>Edmund Lusthaus M.D.</b>		<b>DATE SIGNED</b> <b>8-16-58</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>8/19/58</b>		<b>22b. DATE THEREOF</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Agnes Cemetery, Baltimore, Md.</b>		<b>22d. LOCATION (City, town, or county)</b> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Frank H. Newell</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 21 '58</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: All death certificates have been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ADDITIONAL INFORMATION  
FOR CIVIL ENGINEER

STATE OF MARYLAND

CERTIFICATE OF DEATH

1923

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Residence		Burial Place	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Certificate		Place of Issuance		Official Seal	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08936

8940

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>4yrs.9mos.4days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 14</b> d. STREET ADDRESS <b>5016 Pilgrim Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Parker GROSS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 22, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>19</b> Min. <b>58</b>	11. IF UNDER 24 HRS. Months <b>4</b> Days <b>4</b> Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Parker</b>		14. MOTHER'S MAIDEN NAME <b>Justina Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Passive congestion of heart</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO (c) <b>-</b> INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>420.0</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH (a) <b>C.B.S. assoc. with dist. of growth, metabolism or nutrition, with senile brain disease with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> to <b>August 4, 1958</b> , that I last saw the deceased alive on <b>August 4, 1958</b> , and that death occurred at <b>4:00P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		DATE SIGNED <b>8/4/58</b>	
22. BURIAL, CREMATION, REMOVAL (Specify) <b>8-7-58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Kuck</b>		ADDRESS <b>1305 Bayford</b>	
24a. REC'D BY REGISTRAR <b>AUG 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Lewis</b>	



CERTIFICATE OF DEATH

1920

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1875		New York, N.Y.	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Coronary Artery Disease		Chest Pain		2 Weeks		10:00 AM	
Place of Death		Occupation		Education		Marital Status		Religion	
Home		Teacher		High School		Married		Catholic	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Disease	
Jan 15, 1920		10:00 AM		Home		Heart Disease		Coronary Artery Disease	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8941

## CERTIFICATE OF DEATH

Reg. Dist. No.

08937

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> 78 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 LIBERTY ST.</u>		d. STREET ADDRESS <u>1102 LIBERTY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCINDA V. HAINES</u>		4. DATE OF DEATH Month Day Year <u>AUG. 14 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 21, 1980</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EMANUEL HOLLINBAUGH</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE MULL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>MRS W. NEWTON WESTMINSTER, MD.</u>		Address <u>102 LIBERTY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>8 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 13, 1958</u> , to <u>Aug. 14, 1958</u> , that I last saw the deceased alive on <u>Aug. 13, 1958</u> , and that death occurred on <u>Aug. 14, 1958</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>8-16-58</u>	
PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 17 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWBROOK CEM WESTMINSTER MD.</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard Westminster</u>		24a. REC'D BY REGISTRAR <u>Aug 19 1958</u>	
ADDRESS <u>Westminster</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8942

## CERTIFICATE OF DEATH

Reg. Dist. No.

08938

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u> c. LENGTH OF STAY IN 1b <u>45 years</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Carroll</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u> d. STREET ADDRESS <u>Frederick Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Katherine J. Hemler</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>August 23 1958</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 24, 1886</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Delaware</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John W. Magee</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella Crass</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>213-01-3804B</u>		<b>17. INFORMANT</b> Address <u>Mr. Pius Hemler, Taneytown, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>10 yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric Fracture Rt. hip 7/6/58 (Notified Dr. J. T. Marsh-Westminster, Md.)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor 903.0</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>7</u> <u>6</u> <u>19 58</u> p. m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Taneytown Carroll Md.</u>	
<b>21. I certify that I attended the deceased from</b> <u>Feb. 3</u> , 19 <u>41</u> <b>to</b> <u>Aug. 23</u> , 19 <u>58</u> , <b>that I last saw the deceased alive on</b> <u>Aug. 23</u> , 19 <u>58</u> , <b>and that death occurred at</b> <u>10</u> P.M., <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <u>R. S. McVaugh</u> <b>M.D.</b> <u>49 Frederick St. - Taneytown, Md.</u> <b>PHYSICIAN'S NAME (Type)</b> <u>R. S. McVaugh</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>August 28, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Joseph's Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Taneytown, Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C. O. Fuss &amp; Son</u> <b>ADDRESS</b> <u>Taneytown, Maryland</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>AUG 26 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8943

## CERTIFICATE OF DEATH

08939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 18 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>530 S. Streeper St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Margaret</b> Last <b>Voglesang HESELBACH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19,</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 20, 1870</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Conrad Voglesang</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> (c) <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction. Fracture, intracapsular, right hip, femur.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1,</b> 19 <b>58</b> , to <b>August 19,</b> 19 <b>58</b> , that I last saw the deceased alive on <b>August 18,</b> 19 <b>58</b> , and that death occurred at <b>3:25A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
DATE SIGNED <b>8/19/58</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/22/58</b>		22c. NAME OF CEMETERY OR CREMATOR <b>Schwartz's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO.</b> <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hartley Miller</b>				ADDRESS <b>2334 Jefferson St.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Although this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







8944

## CERTIFICATE OF DEATH

08940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gamber, Sykesville Rt. #3</b>		c. LENGTH OF STAY IN IB <b>all of life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS MARION</b> Middle <b>HOFF</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>David Hoff</b>		14. MOTHER'S MAIDEN NAME <b>Martha Lockard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-36-0492</b>	
17. INFORMANT <b>Herman M. Hoff</b>		Address <b>Gamber, Sykesville, Rt. #3</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> DUE TO <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>senile changes</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>several yrs.</b> <b>11</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1940</b> , 19 <b>58</b> , to <b>August 21, 1958</b> , that I last saw the deceased alive on <b>13 August</b> , 19 <b>58</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Liberty Road at Eldersburg</b> DATE SIGNED <b>8.21.58</b> ACTUAL SIGNATURE <b>Wm. H. Lawson, Jr., M.D.</b> PHYSICIAN'S NAME (Type) <b>Sykesville P.O., Maryland</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-23-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>GAMBER, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN R. BYERS, WSETMINSTER, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

NAME OF DECEASED

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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OFFICIAL ATTESTATION OF  
STATE OF MARYLAND  
BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8945

## CERTIFICATE OF DEATH

08941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>P.O. Box 296</b>	
3. NAME OF DECEASED (Type or print) First <b>Irving</b> Middle <b>Elijah</b> Last <b>Holloway</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Delmar, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elijah Holloway</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Hearn</b>	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>222-05-1196</b>	
17. INFORMANT <b>Irving E. Holloway</b>		Address <b>Delmar, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Moderately advanced pulmonary tuberculosis</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 5, 1957</b> , to <b>August 17, 1958</b> , that I last saw the deceased alive on <b>August 17, 1958</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>Henryton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, M.D.</b>		<b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-21-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Delmar Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dorothy M. West</b>		ADDRESS <b>Salisbury, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

# CERTIFICATE OF DEATH

3905

<p>1. NAME OF DECEASED                  [Name of deceased]</p>		<p>2. SEX                  [Sex]</p>	
<p>3. AGE                  [Age]</p>		<p>4. DATE OF BIRTH                  [Date of birth]</p>	
<p>5. PLACE OF BIRTH                  [Place of birth]</p>		<p>6. DATE OF DEATH                  [Date of death]</p>	
<p>7. TIME OF DEATH                  [Time of death]</p>		<p>8. PLACE OF DEATH                  [Place of death]</p>	
<p>9. CAUSE OF DEATH                  [Cause of death]</p>		<p>10. MANNER OF DEATH                  [Manner of death]</p>	
<p>11. SIGNATURE OF DECEASED                  [Signature]</p>		<p>12. SIGNATURE OF WITNESSES                  [Signatures]</p>	
<p>13. SIGNATURE OF PHYSICIAN                  [Signature]</p>		<p>14. SIGNATURE OF CORONER                  [Signature]</p>	
<p>15. SIGNATURE OF JUDGE                  [Signature]</p>		<p>16. SIGNATURE OF CLERK                  [Signature]</p>	

8946

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Edward Horn</b>				4. DATE OF DEATH Month Day Year <b>August 13, 1958</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 5, 1875</b>		
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>- Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>216-10-8944A</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July 21, 1958</b> , to <b>August 13, 1958</b> , that I last saw the deceased alive on <b>August 12, 1958</b> , and that death occurred at <b>1:40A</b> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>8/13/58</b>		
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				Sykesville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>8-15-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Balto</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donny Byers</b> ADDRESS <b>8728 Litchfield Rd. Retimachlawn, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

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CERTIFICATE OF DEATH

1968

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. MARRIAGE		8. OCCUPATION		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
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73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
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82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
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91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

JAMES J. JAMES



8925

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER 27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>237 E. MAIN ST.</b>		d. STREET ADDRESS <b>237 E. MAIN</b>	
3. NAME OF DECEASED (Type or print) First <b>MAUD</b> Middle <b>ESTELLE</b> Last <b>HORNER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 30 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALFRED ALGIRE</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE HOUCK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO ONE</b>	
17. INFORMANT <b>HELEN HORNER</b>		Address <b>237 E. MAIN WESTMINSTER, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PAPILLOCARCINOMATOSIS URINARY BLADDER</b> DUE TO (c) <b>14 MONTHS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOVEMBER 1957</b> to <b>AUGUST 1958</b> , that I last saw the deceased alive on <b>AUGUST 15, 1958</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel J. Wollner</b>		M.D. <b>19 N. CHURCH ST., WESTMINSTER</b>	
PHYSICIAN'S NAME (Type) <b>Daniel J. Wollner</b>		DATE SIGNED <b>8/18/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>AUG. 21-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>FINTSBURG, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David G. Bankard Westminster, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 22 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

Page No. 1

NAME OF DECEASED JAMES H. HARRIS		AGE 65	SEX Male	RACE White	DATE OF BIRTH 1860	PLACE OF BIRTH Maryland
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Retired				CAUSE OF DEATH Heart Disease
DATE OF DEATH 1925		PLACE OF DEATH Home		MANNER OF DEATH Natural		REPORTED BY Physician
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS		SIGNATURE OF WITNESSES J. H. HARRIS		



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

8947

CERTIFICATE OF DEATH

08944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs 7 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First Middle Last		4. DATE OF DEATH <u>8</u> Month <u>30</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>Gus Sevdalis</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Nick A. Kastelloregos</u> Address <u>615 Ponda St. Baltimore 24</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Functional Disease of Heart (Arrhythmia)</u> years (c) <u>Generalized Arteriosclerosis</u> Years			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with disturbance of growth metabolism or nutrition with senile brain disease with psychotic reaction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-18-1954</u> to <u>8-30-1958</u> , that I last saw the deceased alive on <u>8-30-1958</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elizabeth H. Knopp</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hosp.</u> DATE SIGNED <u>8-30-58</u>	
PHYSICIAN'S NAME (Type) <u>Elizabeth H. Knopp</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greek</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lambros Inc 440 E. North Ave</u> ADDRESS		24a. REC'D BY REGISTRAR <u>9/2/58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## CERTIFICATE OF DEATH

1921

DATE OF DEATH

PLACE

10/10/21

FAMILY BOND

1030

1030

REGISTERED (J.N.)

10/10/21

10/10/21

10/10/21



8948

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>16yrs. 4mos. 9days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1005 N. Charles St. #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Aloysius</b> Middle <b>H.</b> Last <b>Kennedy</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR: Months <b>63</b> Days <b>13</b> Hours <b>19</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland - Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Kennedy</b>		14. MOTHER'S MAIDEN NAME <b>J. Winifred O'Donnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>491X</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Deficiency without psychosis.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 27, 1955</b> , to <b>August 13, 1958</b> , that I last saw the deceased alive on <b>August 13, 1958</b> , and that death occurred at <b>7:00P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Julian Radcykowycz</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/13/58</b>	
PHYSICIAN'S NAME (Type) <b>Julian Radcykowycz, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/16.58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. McKenney</b>		24a. REC'D BY REGISTRAR <b>Aug 18 '58</b>	
ADDRESS <b>Seeth - 17, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1884		PLACE OF BIRTH Maryland	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Teacher		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH 1949		PLACE OF DEATH Home	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married		PREVIOUS ILLNESS None	
DATE OF INTERVIEW 1949		INTERVIEWER J. H. Smith		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
DATE OF DEATH 1949		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH 1949	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married		PREVIOUS ILLNESS None	
DATE OF INTERVIEW 1949		INTERVIEWER J. H. Smith		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
DATE OF DEATH 1949		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DATE OF DEATH 1949	

8949

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>		c. LENGTH OF STAY IN 1b <b>50 Yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, R.D.2 (Myers District)</b>				d. STREET ADDRESS <b>Westminster, R.D.2 (Myers District)</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lewis</b> First <b>Henry</b> Middle <b>Kirkhoff</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 58</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/28/1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming, Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Lewisburg, Ohio.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Kirkhoff</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Lookingbill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lewis H. Kirkhoff</b> Address <b>Westminster, Md. R.D.2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency + ischemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February</b> , 19 <b>57</b> , to <b>August</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>August 3</b> , 19 <b>58</b> , and that death occurred at <b>8:30A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leah Maitland</b>				ADDRESS (Street, city or town, state) <b>Littlestown, Pa</b>			
PHYSICIAN'S NAME (Type) <b>LEAH MAITLAND</b>				DATE SIGNED <b>8/4/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8043

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		COLOR [Illegible]	
EDUCATION [Illegible]		RELIGION [Illegible]		SERVICE [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

RECEIVED  
 DEPARTMENT OF HEALTH  
 BALTIMORE, MARYLAND  
 [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8950

CERTIFICATE OF DEATH

08947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City 311</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>K. Lautenberger</u> Last <u>McCoy</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry J. Pirre</u>		14. MOTHER'S MAIDEN NAME <u>Isabella McCoy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-3147</u>	
17. INFORMANT <u>Christian Lautenberger</u> Address <u>8323 Spaulding</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Malignant Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerotic Heart Disease</u> (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involutional Psychotic Reaction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 31, 1958</u> , to <u>August 17, 1958</u> , that I last saw the deceased alive on <u>August 17, 1958</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elisabeth Knopp</u>		DATE SIGNED <u>8-17-58</u>	
PHYSICIAN'S NAME (Type) <u>Elisabeth Knopp</u>		M.D. <u>Springfield State Hospital</u> <u>Sykesville, MD</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u> ADDRESS <u>8728 Litaly Road. Randallstown.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1920

Rev. 1917-18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH		6. PLACE OF DEATH	
JAMES M. JONES		Male		35		White		Maryland		Maryland	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. PLACE OF INTERMENT		12. NAME OF MINISTER	
April 15, 1920		10:30 A.M.		Heart Disease		Natural		St. Paul's Episcopal Church		Rev. J. M. Jones	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF MINISTER		16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF DECEASED	
19. NAME OF DECEASED		20. SEX		21. AGE		22. RACE		23. PLACE OF BIRTH		24. PLACE OF DEATH	
JAMES M. JONES		Male		35		White		Maryland		Maryland	
25. DATE OF DEATH		26. TIME OF DEATH		27. CAUSE OF DEATH		28. MANNER OF DEATH		29. PLACE OF INTERMENT		30. NAME OF MINISTER	
April 15, 1920		10:30 A.M.		Heart Disease		Natural		St. Paul's Episcopal Church		Rev. J. M. Jones	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF MINISTER		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF CLERK		36. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>		c. LENGTH OF STAY IN 1b <b>X Finksburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RD #1 Box 441</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMMA First Leister</b> <b>Agnes</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1867</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>90</b> Days <b>90</b> Hours <b>90</b> Min. <b>90</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Read</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Jane ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>E. Morgan Leister</b>		18. ADDRESS (Street, city or town, state) <b>RD #1 Box 441 Finksburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>1 wk</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1951</b> , to <b>8/3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/3</b> , 19 <b>58</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 W Main St Westminster</b> DATE SIGNED <b>8/3/58</b>			
ACTUAL SIGNATURE <b>G. Allen Moulton</b>		PHYSICIAN'S NAME (Type) <b>G. Allen Moulton</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/6/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		24a. REC'D BY REGISTRAR <b>Aug 5 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			



8952

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN 1b <b>6yrs. 3mos. 27days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Timothy</b> Middle <b>Joseph</b>		McAuliffe <b>McAuliffe</b>	4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 58</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13-6-1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>
13. FATHER'S NAME <b>Daniel McAuliffe</b>		14. MOTHER'S MAIDEN NAME <b>Catherine McDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Springfield Hospital Records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium due to coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>cc2x</b> (b) <b>Pulmonary tuberculosis, far advanced, inactive</b> DUE TO (c) <b>Schizophrenia, paranoid type.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes:</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, paranoid type.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 20, 1954</b> to <b>August 26, 1958</b> , that I last saw the deceased alive on <b>August 25, 1958</b> , and that death occurred at <b>6:45A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>8/26/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-28-58</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>New Catholic</b>	22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leman Luck</b>		ADDRESS <b>5305 Hanford</b>	
24a. REC'D BY REGISTRAR <b>AUG 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0105

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		M		35		JAN 15 1910		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1945		10:30 AM		10:30		30		00	
CERTIFICATE OF DEATH		FEDERAL BUREAU OF INVESTIGATION		U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.		JAN 20 1945	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH-DEATH-REGISTRY



CERTIFICATE OF DEATH

09657

Reg. Dist. No.

8953

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Manchester Md. Rd.</u>		c. LENGTH OF STAY IN 1b <u>60 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>GEORGE</u> Last <u>MECKLEY</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Manheim Township, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Meckley</u>		14. MOTHER'S MAIDEN NAME <u>Catherine (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-24-2594</u>	
17. INFORMANT <u>Dillia Zepp Meckley</u>		Address <u>Manchester Md Rd 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac Dilitation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arterio-Sclerotic Coronary Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>8 mo.</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> 19 <u>58</u> , to <u>August 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 10</u> , 19 <u>58</u> , and that death occurred at <u>11:45 A.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>8/16/58</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		<u>Hampstead, Md.</u> <u>8/16/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 18, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Jacobs Stone Church</u>	22d. LOCATION (City, town, or county) (State) <u>Brodbeck Rd York Co. Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>See Envelope</u> ADDRESS <u>Men Rock, Pa.</u>		24a. REC'D BY REGISTRAR <u>Aug 18 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Carroll S. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  _____</p>		<p>2. SEX                  _____</p>		<p>3. AGE                  _____</p>	
<p>4. DATE OF DEATH                  _____</p>		<p>5. TIME OF DEATH                  _____</p>		<p>6. PLACE OF DEATH                  _____</p>	
<p>7. CAUSE OF DEATH                  _____</p>		<p>8. MANNER OF DEATH                  _____</p>		<p>9. PLACE OF BIRTH                  _____</p>	
<p>10. OCCUPATION                  _____</p>		<p>11. EDUCATION                  _____</p>		<p>12. RELIGION                  _____</p>	
<p>13. MARITAL STATUS                  _____</p>		<p>14. DATE OF MARRIAGE                  _____</p>		<p>15. NAME OF SPOUSE                  _____</p>	
<p>16. NAME OF PHYSICIAN                  _____</p>		<p>17. NAME OF NURSE                  _____</p>		<p>18. NAME OF MINISTER                  _____</p>	
<p>19. NAME OF FUNERAL HOME                  _____</p>		<p>20. NAME OF CEMETERY                  _____</p>		<p>21. NAME OF BURIAL PLACE                  _____</p>	
<p>22. NAME OF NEXT OF KIN                  _____</p>		<p>23. NAME OF SURVIVOR                  _____</p>		<p>24. NAME OF WITNESS                  _____</p>	
<p>25. NAME OF REGISTRAR                  _____</p>		<p>26. NAME OF CLERK                  _____</p>		<p>27. NAME OF ASSISTANT                  _____</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08950

8954

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: SYKESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1556.2</u> <u>Silver Spring.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital.</u>		d. STREET ADDRESS <u>8407 16 th. St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Robert Whitney SR. MILLER SR.</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>August 1 1958</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11-20-90</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>67</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <u>— — — —</u> <b>IF UNDER 24 HRS.</b> <u>— — — —</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Accounting Div. Army &amp; NAVY Army U.S. Gov't</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Colorado</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Richard F. Miller</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>RACHEL STROTHER Ann EX-STROTHER</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes Army 1910-1925</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT</b> <u>Records of Springfield State Hospital.</u>		<b>Address</b> <u>Sykesville, Md.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> <u>Pyelonephritis, bilateral</u> DUE TO (b) <u>Pneumonia.</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>026x Chronic Brain Syndrome ass. c CNS syphilis, meningoencephalitis and psychotic reaction.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>August 1955</u> , to <u>August 1 1958</u> , that I last saw the deceased alive on <u>August 1 1958</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <u>Springfield State Hospital</u> <b>DATE SIGNED</b> <u>Walter Knopp</u>			
<b>ACTUAL SIGNATURE</b> <u>Walter Knopp</u>		<b>PHYSICIAN'S NAME (Type)</b> <u>Walter Knopp, M.D.</u> <u>Sykesville, Maryland.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>8/6/58</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ARLINGTON NAT'L CEMETERY</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Aug 7 '58</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>W. Lesnick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <u>JOHN J. JONES</u></p>	
<p>AGE: <u>45</u> YEARS</p>	
<p>SEX: <u>MALE</u></p>	
<p>RACE: <u>WHITE</u></p>	
<p>DATE OF BIRTH: <u>1905</u></p>	
<p>PLACE OF BIRTH: <u>NEW YORK</u></p>	
<p>DATE OF DEATH: <u>1950</u></p>	
<p>PLACE OF DEATH: <u>HOME</u></p>	
<p>CAUSE OF DEATH: <u>HEART DISEASE</u></p>	
<p>IMMEDIATE CAUSE: <u>MYOCARDIAL INFARCTION</u></p>	
<p>UNDERLYING CAUSE: <u>ARTERIOSCLEROSIS</u></p>	
<p>DATE OF BURIAL: <u>1950</u></p>	
<p>PLACE OF BURIAL: <u>CATHOLIC CEMETERY</u></p>	
<p>SIGNATURE OF PHYSICIAN: <u>DR. J. H. SMITH</u></p>	
<p>SIGNATURE OF REGISTRAR: <u>W. H. JONES</u></p>	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08951

Reg. Dist. No.

8955

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 3mos. 2days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1212 Walters Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Frieda</b> Middle <b>Ermine</b> Last <b>Wieman MOORE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18,</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 21, 1890</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public Health Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>Levi (Wieman) WYMAN</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Wieman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.0</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with presenile brain disease with psychotic reaction. Decubitus ulcer on back.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 16,</b> 19 <b>56</b> , to <b>August 18,</b> 19 <b>58</b> , that I last saw the deceased alive on <b>August 18,</b> 19 <b>58</b> , and that death occurred at <b>6:15P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		DATE SIGNED <b>8/19/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-21-58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		22d. LOCATION (City, town or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b>		ADDRESS <b>305 Bayford</b>	
24a. REC'D BY REGISTRAR <b>Aug 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15, 1900		New York City, N.Y.	
Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease		Jan 20, 1945		Home	
Physician		Manner of Death		Burial or Disposition		Date of Burial		Place of Burial	
Dr. J. Smith		Natural		Buried		Jan 22, 1945		Catholic Cemetery, Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

JAN 21 1945

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof is to be furnished to the local health officer of the city or county in which the death occurred.

8956

## CERTIFICATE OF DEATH

08952

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b> 10X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Motter</b> Last <b>Motter</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 15, 1877</b>		9. AGE (In years lost birthday) <b>80</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John C. Motter</b>			14. MOTHER'S MAIDEN NAME <b>Effie Marken</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Springfield State Hospital Record</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Mins.</b> <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paranoid state</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <b>November 1, 1955</b> , to <b>August 22, 1958</b> , that I last saw the deceased alive on <b>August 21, 1958</b> , and that death occurred on <b>August 22, 1958</b> at <b>2:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elisabeth M. Knopp</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>8/22/58</b>	
PHYSICIAN'S NAME (Type) <b>Elisabeth M. Knopp, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>not buried</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home</b>				ADDRESS <b>5103 Wisconsin Washington D.C.</b>		24. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
DATE <b>AUG 27 '58</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1905

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

<p>PLACE TO BE FILLED BY THE REGISTRAR</p> <p>NAME OF DECEASED <i>John Doe</i></p> <p>AGE <i>45</i></p> <p>SEX <i>Male</i></p> <p>DATE OF DEATH <i>Jan 15 1905</i></p> <p>TIME OF DEATH <i>10:30 AM</i></p> <p>PLACE OF DEATH <i>Home</i></p> <p>CAUSE OF DEATH <i>Heart Disease</i></p> <p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p> <p>INTERMEDIATE CAUSE OF DEATH <i>None</i></p> <p>PRE-EXISTING DISEASES <i>None</i></p> <p>DATE OF BIRTH <i>Jan 15 1860</i></p> <p>PLACE OF BIRTH <i>MD</i></p> <p>EDUCATION <i>None</i></p> <p>OCCUPATION <i>None</i></p> <p>RELIGION <i>None</i></p> <p>USUAL RESIDENCE <i>None</i></p> <p>DATE OF DEATH <i>Jan 15 1905</i></p> <p>TIME OF DEATH <i>10:30 AM</i></p> <p>PLACE OF DEATH <i>Home</i></p> <p>CAUSE OF DEATH <i>Heart Disease</i></p> <p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p> <p>INTERMEDIATE CAUSE OF DEATH <i>None</i></p> <p>PRE-EXISTING DISEASES <i>None</i></p> <p>DATE OF BIRTH <i>Jan 15 1860</i></p> <p>PLACE OF BIRTH <i>MD</i></p> <p>EDUCATION <i>None</i></p> <p>OCCUPATION <i>None</i></p> <p>RELIGION <i>None</i></p> <p>USUAL RESIDENCE <i>None</i></p>		<p>NAME OF REGISTRAR <i>John Doe</i></p> <p>DATE OF DEATH <i>Jan 15 1905</i></p> <p>TIME OF DEATH <i>10:30 AM</i></p> <p>PLACE OF DEATH <i>Home</i></p> <p>CAUSE OF DEATH <i>Heart Disease</i></p> <p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p> <p>INTERMEDIATE CAUSE OF DEATH <i>None</i></p> <p>PRE-EXISTING DISEASES <i>None</i></p> <p>DATE OF BIRTH <i>Jan 15 1860</i></p> <p>PLACE OF BIRTH <i>MD</i></p> <p>EDUCATION <i>None</i></p> <p>OCCUPATION <i>None</i></p> <p>RELIGION <i>None</i></p> <p>USUAL RESIDENCE <i>None</i></p>
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NOTICE TO THE PUBLIC: This certificate is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 15th day of January, 1905.

8957

CERTIFICATE OF DEATH

08953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Springfield State Hosp.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore city 311</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hosp.</u>		d. STREET ADDRESS <u>3202 Moravia Ave, Balt 14, Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Smith</u> Last <u>Murkey</u>		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>19 58</u>	
5. SEX <u>femal</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/75</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>	IF UNDER 24 HRS. Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dependent</u>	
11. BIRTHPLACE (State or foreign country) <u>USA BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>P. Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Son. 3006 Beverley Rd</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Branchopneumonia due to undetermined cause</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile atrophy, and marasm</u> (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-9</u> , 19 <u>58</u> , to <u>8-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-16-58</u> , 19 <u>58</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Ellis S. Margholin</u> M.D.		PHYSICIAN'S NAME (Type) <u>Ellis S. Margholin</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL AUG. 20. 58 OAK LAWN</u>		22b. DATE THEREOF <u>—</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. MO.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.A. Heemans 6067 HARFORD RD</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>AUG 20 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		White		1/1/1900		1/1/1950		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of completion		18. Registrar's name		19. Registrar's title		20. Registrar's address	
Jane Doe		Wife		123 Main St		Baltimore		MD		21201		1/1/1950		John Doe		Registrar		123 Main St	



8958

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILBERT</b> Middle <b>LINCOLN</b> Last <b>ORNDORFF</b>		4. DATE OF DEATH Month <b>8</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>2</b>	11. IF UNDER 24 HRS. Hours <b>2</b> Min. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Orndorff</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sheets</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213-16-0228</b>	
17. INFORMANT <b>Record, Springfield State Hospital, Sykesville</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Old and New Myocardial infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease with angina pectoris year?</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute Brain Syndrome associated with metabolic disturbance (uremia)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-- -- --</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>8/1</b> 19 <b>58</b> p. m. <b>12:55</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-- -- --</b>		20f. (City or town) (County) (State) <b>-- -- --</b>	
21. I certify that I attended the deceased from <b>7/8</b> , 19 <b>58</b> , <b>8/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/1</b> , 19 <b>58</b> , and that death occurred at <b>12:55</b> <b>PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>8/1/58</b>			
ACTUAL SIGNATURE <b>Yasuo Takahashi</b>		M.D. <b>Sykesville, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Yasuo Takahashi, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b>		24a. REC'D BY REGISTRAR <b>Wm. A. Horst</b>	
ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. A. Horst</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Old and new Myocardial infarct

FOR STATE  
HEALTH DEPT.

8926

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Court Place</b>		d. STREET ADDRESS <b>Court Place</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JANE</b> Last <b>RAILING</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5 1895</b> 9. AGE (In years last birthday) <b>63</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>SOMERSET CO, PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DONALD CRAIG</b>		14. MOTHER'S MAIDEN NAME <b>GRACE TAIT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MR W.E. RAILING</b> Address <b>DENNS GROVE NEW JERSEY</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Barbiturate Poisoning</b> <b>970.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested barbiturates.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>8/4/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Westminster Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/5/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 7, 58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr.</b> ADDRESS <b>Westminster, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 7 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Paul F. Guerin</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8959

Item 1 Film 232 8-11-58 et

## CERTIFICATE OF DEATH

08956

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carrise County</u> <u>Linger Boarding Home</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>Maryland</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>111 Reisterstown Road #8</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>F.</u> Last <u>RONNENBERG</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hughes Lumber Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Catonsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ronnenberg</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mrs. Dorothy Denny-1023 Southwest 6th St.</u>		Address <u>Miami, Florida</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis, Arteriosclerosis -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ephysema - Bronchitis -</u> DUE TO (c) <u>3 Aug 58</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>3 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3 August</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Apartment 7, Md</u> DATE SIGNED <u>3 Aug 58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker &amp; Sons</u> ADDRESS <u>Balto - 17, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Tucker</u>			



# CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF DEPARTMENT CLERK	

RECORDED  
INDEXED



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20b Film 233 8-20-58 am

8960

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 08957

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millers</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie 02X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>River Valley Ranch</b>			d. STREET ADDRESS <b>5 Chain-O-Hill, Markley Pk.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>LEROY</b> Last <b>RUSSELL</b>			4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1914</b>		9. AGE (In years last birthday) <b>44</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l. Plastic</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co., Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William R. Russell</b>			14. MOTHER'S MAIDEN NAME <b>Laura M. Shorter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>217-065035</b>		17. INFORMANT Address <b>Mrs. Elsie M. Russell Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compression of spinal cord</b> <b>902.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of fifth cervical vertebra</b> (c) <b>Due to the underlying cause lost.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dived into shallow water</b>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>Aug. 8, 1958</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <b>River Valley Ranch</b>	
		20f. (City or town) <b>Millers</b>		(County) <b>Carroll</b>	
				(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Petty</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-13-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>
22d. LOCATION (City, town, or county) <b>Howard Co., Maryland</b>			(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. R. Huntington</b>			24a. REC'D BY REGISTRAR <b>Glen Burnie, Maryland</b>		
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		
DATE <b>AUG 12 1958</b>					

HEALTH DEPT.  
CITY OF BALTIMORE

1900

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE			
JAMES M. JONES		35		Male		White		Roman Catholic		Married		High School		Clerk		1234 Main St.		Jan 15, 1900		City of Baltimore		Died of		Natural		J. M. Jones		Jan 15, 1900			
BORN		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
JAN 10, 1865		BALTIMORE		JAMES M. JONES		MARY M. JONES		JAMES M. JONES		MARY M. JONES		JAMES M. JONES		None		None		None		None		None		None		None		None		None	
MARRIED		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
JAN 10, 1865		BALTIMORE		JAMES M. JONES		MARY M. JONES		JAMES M. JONES		MARY M. JONES		JAMES M. JONES		None		None		None		None		None		None		None		None		None	
PREVIOUS ILLNESS		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS SURGERY		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS TRAUMA		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS ACCIDENT		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS POISONING		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS DRUGS		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS ALCOHOL		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS TOBACCO		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	
PREVIOUS OTHER		DATE		PLACE		PARENTS		FATHER		MOTHER		SIBLINGS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None		None		None		None		None	

1. TO BE FILLED BY THE EXAMINER  
2. TO BE FILLED BY THE EXAMINER  
3. TO BE FILLED BY THE EXAMINER  
4. TO BE FILLED BY THE EXAMINER  
5. TO BE FILLED BY THE EXAMINER  
6. TO BE FILLED BY THE EXAMINER  
7. TO BE FILLED BY THE EXAMINER  
8. TO BE FILLED BY THE EXAMINER  
9. TO BE FILLED BY THE EXAMINER  
10. TO BE FILLED BY THE EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and take use as the burial-transit permit. Then please remove corban postcard and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08958

8961

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route #1, Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Clayton</u> Last <u>RUTH</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 9, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock clerk - ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>William C. Ruth</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Sprecker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-4313</u>	
17. INFORMANT <u>Records of Springfield State Hospital</u>		Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old and new myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u> yrs. - <u>  </u> hours <u>  </u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from <u>March 21</u> , 19 <u>57</u> , to <u>August 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 3</u> , 19 <u>58</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>8-4-58</u>			
ACTUAL SIGNATURE <u>Walter Knopp</u>		M.D. <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Walter Knopp, M. D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Rouse</u>		ADDRESS <u>Hagerstown, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

# CERTIFICATE OF DEATH

3281

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED: [illegible]  
AGE: [illegible] SEX: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible]

DATE OF MARRIAGE: [illegible] PLACE OF MARRIAGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible]

DATE OF MARRIAGE: [illegible] PLACE OF MARRIAGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible]

DATE OF MARRIAGE: [illegible] PLACE OF MARRIAGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible]

DATE OF MARRIAGE: [illegible] PLACE OF MARRIAGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it must be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08959

8962

CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo. 9 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>627 E. 33rd Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Ethel Margaret Schuncke</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>August 6, 19 58</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 30, 1901</b>
<b>9. AGE</b> (In years last birthday) <b>57</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min. <b>57</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife - Clerk</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Robert Powell</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ruth Pierce</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>	
<b>17. INFORMANT</b> <b>Springfield State Hospital, Sykesville, Md.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>581.0</b> IMMEDIATE CAUSE (a) <b>Branchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute pyelonephritis</b> DUE TO (c) <b>Portal cirrhosis of the liver</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. of unknown cause.</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>July 1, 19 58</b> , to <b>August 6, 19 58</b> , that I last saw the deceased alive on <b>August 6, 19 58</b> , and that death occurred at <b>11:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland, August 7, 1958</b> DATE SIGNED			
<b>ACTUAL SIGNATURE</b> <b>Francisco Piqueras, M.D.</b>		<b>PHYSICIAN'S NAME (Type)</b> <b>Francisco Piqueras, M.D.</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>8/9/58 Burial</b>		<b>22b. DATE THEREOF</b> <b>8/9/58</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenmount</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Balto.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Rita Wiedefeld</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE AUG 8 '58</b>	
<b>ADDRESS</b> <b>960 E. Buddle St</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. J. Smith</b>	



8963

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>Sykesville, Springfield St. Hosp.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Res. Inst. of admission) o. STATE <b>Md</b> b. COUNTY <b>Md, Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>City Sykesville</b>		c. LENGTH OF STAY IN lb <b>4y, 7 mo, 8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hosp.</b>			d. STREET ADDRESS <b>4423 Buena vista Ave, Balt. 11</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Mason</b> Last <b>SHEELEY</b>			4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-13-01</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>William Sheeley (dec'd)</b>		
14. MOTHER'S MAIDEN NAME <b>Ida Sheeley</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>218-32-3182</b>		17. INFORMANT <b>Mrs. Mildred N. Sheeley</b> Address <b>444 Aigburth Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Right lower lobe.</b> <b>493X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Pyelonephritis, R. Kidney = calculus.</b> (c) <b>Pick's disease of the brain (possible).</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>8/13/58</b> , 19 <b>58</b> , to <b>8/16/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/16/58</b> , 19 <b>58</b> , and that death occurred at <b>12:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Edmund Lusthaus</b> M.D. <b>8/17/58</b> DATE SIGNED					
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 20, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	
22d. LOCATION (City, town, or county) <b>Pikesville, Maryland</b>		22e. (State) <b>Md.</b>		22f. (County) <b>Harford</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		ADDRESS <b>3631 Falls Road</b>		24a. REC'D BY REGISTRAR <b>AUG 19 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24c. (City or town) <b>Baltimore</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1950		Home	
Cause of Death		Disease		Organ		Manner		Occupation	
Heart Disease		Coronary Artery Disease		Heart		Natural		Teacher	
Date of Birth		Place of Birth		Married		Signature of Physician		Signature of Registrar	
Jan 1, 1905		Baltimore, Md.		Yes		[Signature]		[Signature]	
Date of Burial		Place of Burial		Buried		Signature of Minister		Signature of Registrar	
Jan 20, 1950		St. Mary's Church		Yes		[Signature]		[Signature]	
Date of Issuance		Place of Issuance		Issued		Signature of Registrar		Signature of Registrar	
Jan 25, 1950		Baltimore, Md.		Yes		[Signature]		[Signature]	



8964

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2 mo. 8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City, 2120 Edmondson Ave. 3V01-4</b> d. STREET ADDRESS <b>Methodist Home for Aged</b> <b>2211 W. Roger's Ave.</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALICE E. SHOCKLEY</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>August 7 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1869</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland - Snow Hill</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Mumford</b>	
14. MOTHER'S MAIDEN NAME <b>Eleanor Godfrey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMATION Address <b>Springfield State Hospital, Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenterial thrombosis due to arteriosclerosis of mesenterial artery.</b> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic rheumatic heart disease with mitral insufficiency.</b> DUE TO (c) <b>General arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. with psychotic reaction.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1958</b> , to <b>August 7, 1958</b> , that I last saw the deceased alive on <b>August 7, 1958</b> , and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Francisco Piqueras, M.D. Sykesville, Maryland, August 7, 1958</b>			
ACTUAL SIGNATURE <b>Francisco Piqueras</b>		PHYSICIAN'S NAME (Type) <b>Francisco Piqueras, M.D. Springfield State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/9/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tucker &amp; Sons</b>		ADDRESS <b>North + Penna Ave</b>	24a. REC'D BY REGISTRAR <b>AUG 8 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Wm J. Tucker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and coroner. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



WARREN STATE DEPARTMENT OF HEALTH—Baltimore 16

165

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08962

8965

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>		LENGTH OF STAY (in this place) <u>4 HRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER, MD.</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SANDY MOUNT ROAD</u>				STREET ADDRESS <u>FINKSBURG RD#1, MD.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>LOTTIE MAE SLOPP</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>AUG. 2 19 58</u>			
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>single</u>	<b>8. DATE OF BIRTH</b> <u>AUG 25 1895</u>		<b>9. AGE last birthday</b> <u>62</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>FINKSBURG, RD#1, MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>JOHN SLOPP</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MINERUA TAYLOR</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>JOHN L. SLOPP, FINKSBURG, MD. RD#1</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>260X IMMEDIATE CAUSE (A)</b> <u>Chronic Nephritis</u>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Myocardial (chr) Hypertension</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>Diabetes</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 7, 19 58</u> <b>to</b> <u>Aug 2, 19 58</u> <b>that I last saw the deceased alive on</b> <u>Aug 2, 19 58</u> <b>and that death occurred at</b> <u>10:30 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. C. Smith</u>				<b>ADDRESS</b> (Street, city, town, state) <u>103 E Main Westminster, MD.</u>		<b>DATE SIGNED</b> <u>Aug 2 19 58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>AUG 5, 1958</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>BETHEL CEMETERY</u>		<b>LOCATION (City, town, or county) (State)</b> <u>CARROLLTON CARROLL CO MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>James E. Myers Jr.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James E. Myers Jr.</u>		<b>ADDRESS</b> <u>Westminster Md.</u>	
<b>DATE</b> <u>AUG 5 1958</u>							

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

# CERTIFICATE OF DEATH

2863

REG. DIST. 144

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. OCCUPATION: [illegible]

7. MARITAL STATUS: [illegible]

8. CAUSE OF DEATH: [illegible]

9. PLACE OF DEATH: [illegible]

10. DATE OF DEATH: [illegible]

11. SIGNATURE OF PHYSICIAN: [illegible]

12. SIGNATURE OF REGISTRAR: [illegible]

13. SIGNATURE OF WITNESS: [illegible]

14. SIGNATURE OF DECEASED: [illegible]

15. SIGNATURE OF NEXT OF KIN: [illegible]

16. SIGNATURE OF CLERGYMAN: [illegible]

17. SIGNATURE OF BURIAL OFFICIAL: [illegible]

18. SIGNATURE OF FUNERAL HOME: [illegible]

19. SIGNATURE OF CEMETERY: [illegible]

20. SIGNATURE OF OTHER: [illegible]

21. SIGNATURE OF OTHER: [illegible]

22. SIGNATURE OF OTHER: [illegible]

23. SIGNATURE OF OTHER: [illegible]

24. SIGNATURE OF OTHER: [illegible]

25. SIGNATURE OF OTHER: [illegible]

26. SIGNATURE OF OTHER: [illegible]

27. SIGNATURE OF OTHER: [illegible]

28. SIGNATURE OF OTHER: [illegible]

29. SIGNATURE OF OTHER: [illegible]

30. SIGNATURE OF OTHER: [illegible]

31. SIGNATURE OF OTHER: [illegible]

32. SIGNATURE OF OTHER: [illegible]

33. SIGNATURE OF OTHER: [illegible]

34. SIGNATURE OF OTHER: [illegible]

35. SIGNATURE OF OTHER: [illegible]

36. SIGNATURE OF OTHER: [illegible]

37. SIGNATURE OF OTHER: [illegible]

38. SIGNATURE OF OTHER: [illegible]

39. SIGNATURE OF OTHER: [illegible]

40. SIGNATURE OF OTHER: [illegible]

41. SIGNATURE OF OTHER: [illegible]

42. SIGNATURE OF OTHER: [illegible]

43. SIGNATURE OF OTHER: [illegible]

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STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08963

8966

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Westminster Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>James</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 10, 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dennis Smith</u>		14. MOTHER'S MAIDEN NAME <u>Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. C.C. Williams, Finksburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.-V. Disease</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Cystitis due to Prostatic Hypertrophy</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I attended the deceased from <u>4-3-53</u> , 19 <u>  </u> , to <u>8-21-58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>8-19-58</u> , 19 <u>  </u> , and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Hanover Rd.</u> DATE SIGNED <u>8-22-58</u>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. <u>Reisterstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>		ADDRESS <u>Reisterstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. Molsworth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8967 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 MOS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LIBERTY ROAD RT 41</u>		d. STREET ADDRESS <u>18 GUN POWDER RD</u>	
3. NAME OF DECEASED (Type or print) <u>ERWIN HAMILTON SQUIRES</u>		4. DATE OF DEATH <u>Aug 19 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 6 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CENTURY THEATRE</u>	
11. BIRTHPLACE (State or foreign country) <u>WARREN PA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE SQUIRES</u>		14. MOTHER'S MAIDEN NAME <u>ELLA HYATT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-10-4372</u>	
17. INFORMANT <u>CHARLOTTE AUSTIN</u>		Address <u>18 GUN POWDER RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 MIN.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 23 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SCANDIA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SCANDIA PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert B. D. 7110 BELAIR RD</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 25 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MICHIGAN - ANN ARBOR 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1880		ANN ARBOR		ANN ARBOR		MICHIGAN		MICHIGAN	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
DRIVER		HIGH SCHOOL		MARRIED		METHODIST		DEMOCRAT		NONE		NONE		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		SIGNS OF LIFE		POST-MORTEM	
JAN 15 1920		ANN ARBOR		10:00 AM		98.6		70		20		120/80		NONE		NONE	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		CITY		COUNTY		STATE		FEDERAL REGISTRATION NO.		STATE REGISTRATION NO.	
J. H. HARRIS		M.D.		JAN 15 1920		ANN ARBOR		ANN ARBOR		MICHIGAN		MICHIGAN		12345		67890	



## CERTIFICATE OF DEATH

08965

Reg. Dist. No.

8968

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 28 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>-</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Augustus</b> Middle <b>Riggs</b> Last <b>Stackhouse</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 24, 1864</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Hammond Stackhouse</b>				14. MOTHER'S MAIDEN NAME <b>Emily Burdette</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>-</b> DUE TO (c) <b>-</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 25, 1958</b> , to <b>August 23, 1958</b> , that I last saw the deceased alive on <b>August 22, 1958</b> , and that death occurred at <b>2:20A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>8/23/58</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>8-26-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stackhouse Family Cemetery Howard Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Walz Jr.</b>				ADDRESS <b>Winifred Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1880	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH	
1234 Main St. Baltimore, Md.		Carpenter		Heart Disease		Home	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
Jan 15, 1925		10:30 AM		Home		Natural	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 15, 1925		Jan 15, 1925		Jan 15, 1925		Jan 15, 1925	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8969

CERTIFICATE OF DEATH

Reg. Dist. No.

08966

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> 03x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pullen Nursing Home</b>		d. STREET ADDRESS <b>6714 Meekins Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles E. Trott</b> First Middle Last		4. DATE OF DEATH <b>8 - 23 1957</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Millwork</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Melville Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216.10.4395A</b>	
17. INFORMANT <b>William F. Trott</b>		Address <b>6714 Meekins Ave. 7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia bilateral</b> DUE TO <b>490x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac failure</b> DUE TO <b>2 days</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-17</b> , 19 <b>57</b> , to <b>8-23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-23</b> , 19 <b>57</b> , and that death occurred at <b>11:20 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bertrand R. Gau</b> M.D.		ADDRESS (Street, city or town, state) <b>37 Central Ave</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Bertrand R. GAU</b>		<b>SYKESVILLE Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Oakland</b>	22d. LOCATION (City, town, or county) (State) <b>Sykesville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd. 7</b>	
24a. REC'D BY REGISTRAR <b>AUG 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

DECEASED NAME JAMES H. WOODWARD		SEX Male		AGE 68	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Dec. 23, 1886		PLACE OF DEATH Baltimore, Md.	
STREET ADDRESS 2714 Madison Ave.		CITY Baltimore		STATE Md.	
OCCUPATION Retired		CAUSE OF DEATH Heart Failure		MANNER OF DEATH Natural	
DATE OF DEATH Dec. 23, 1954		TIME OF DEATH 10:30 A.M.		PLACE OF INTERMENT Green-Wood Cemetery	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)	



11-50 (REVISED 1-54)  
 DEPARTMENT OF HEALTH  
 BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08967

Reg. Dist. No.

8970

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2910 McElderry St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>Felicia</b> Last <b>WESTERFIELD</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 10, 1918</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Branchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, catatonic type. Decubitus ulcers</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 21, 1958</b> , to <b>August 3, 1958</b> , that I last saw the deceased alive on <b>August 3, 1958</b> , and that death occurred at <b>1:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>8/4/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/6/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE CENT</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.F. Hoffmann</b>		ADDRESS <b>3218 Hudson St.</b>	
24a. REC'D BY REGISTRAR <b>AUG 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

CERTIFICATE OF DEATH

22778

DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
1900		Maryland		1900		Maryland	
SEX		AGE		CAUSE OF DEATH		MANNER OF DEATH	
Male		25		Diphtheria		Natural	
OCCUPATION		EDUCATION		PREVAILING DISEASE		PREVAILING WEATHER	
None		None		None		None	
SPECIAL INSTRUCTIONS		SPECIAL INSTRUCTIONS		SPECIAL INSTRUCTIONS		SPECIAL INSTRUCTIONS	
None		None		None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
None		None		None		None	
DATE OF REGISTRATION		PLACE OF REGISTRATION		DATE OF REGISTRATION		PLACE OF REGISTRATION	
1900		Maryland		1900		Maryland	

8971

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Sykesville</u> <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Aberdeen, HANFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>8 years, 21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Marie</u> Last <u>WHEELER</u>		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>fem.</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/21</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>18</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Albert Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Marie Colgan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>491X</u> DUE TO (c) <u>491X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental Deficiency without psychosis, imbecile level, epilepsy, right brachial plexis paralysis, due to birth injury, tumor, left hemisphere, cerebellum.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>cerebellum.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 20, 1954</u> , to <u>August 18, 1958</u> , that I last saw the deceased alive on <u>August 17, 1958</u> , and that death occurred at <u>5:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>		DATE SIGNED <u>8/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>		ADDRESS (Street, city or town, state) <u>Springfield Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Tanning</u>		24a. REC'D BY REGISTRAR <u>AUG 21 58</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>1/15/1900</u></p>	
<p>5. Place of birth: <u>Baltimore, Md.</u></p>		<p>6. Usual residence: <u>123 Main St., Baltimore, Md.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Date of death: <u>12/25/1945</u></p>	
<p>9. Time of death: <u>10:30 AM</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>12/26/1945</u></p>		<p>14. Office of registration: <u>Baltimore, Md.</u></p>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13 Film G233 9-5-58 et

Reg. Dist. No.

8972

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Ridgerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrell</u> 02X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Diane May Whitney</u>		4. DATE OF DEATH <u>August 28</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1947</u>
9. AGE (In years last birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grade school</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin K. Whitney</u>		14. MOTHER'S MAIDEN NAME <u>Grace May Preston Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Grace May Preston</u>	
17. INFORMANT <u>Grace May Preston</u>		Address <u>Gambrell, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture base of skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car pulled out in front of truck</u>	
20c. TIME OF INJURY Month, Day, Year <u>8/28 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ridgerville Rd 40</u>	20f. CITY or town (County) (State) <u>Carroll Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>August 28, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>SEP 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 1 only may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HOSPITAL

1900

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED  
DATE  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
PLACE OF BURIAL

DATE OF DEATH  
TIME OF DEATH  
AGE  
SEX  
OCCUPATION  
EDUCATION  
RELIGION  
MARRIAGE

PREVIOUS ILLNESS  
PREVIOUS SURGERY  
PREVIOUS TRAUMA  
PREVIOUS DRUGS  
PREVIOUS ALCOHOL  
PREVIOUS TOBACCO  
PREVIOUS OTHER

SIGNATURE OF MEDICAL EXAMINER  
DATE  
PLACE  
OFFICE

## CERTIFICATE OF DEATH

Reg. Dist. No. **08970****8973**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 mos. 13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>527 Dale Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude May Shelley</b> Middle <b>WITHERS</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 19, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Shelley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Blanche -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.0</b> (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b> <b>Diabetes Mellitus.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9, 1958</b> to <b>August 22, 1958</b> , that I last saw the deceased alive on <b>August 21, 1958</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ellis S. Margolin</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Ellis Margolin, M.D.</b>		DATE SIGNED <b>8/22/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 24, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film 232 8/35/58 gaj

08971

8927

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD 4</u>		d. STREET ADDRESS <u>RD 4</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSIE REESE WOLF</u>		4. DATE OF DEATH Month Day Year <u>Aug 6 19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 11, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANCIS W. REESE</u>		14. MOTHER'S MAIDEN NAME <u>LIZAJ. COPPERSMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS OTTO SEIPP WESTMINSTER MD</u>		Address <u>RD 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.C.V. disease with hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Aug 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>58</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>8-6-58</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		ADDRESS (Street, city or town, state) <u>105 E MAIN ST WESTMINSTER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 9, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TRINITY LUTHERAN CEM. SMALLWOOD MD.</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Bankard Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			



CERTIFICATE OF DEATH

2003

15

NAME OF DECEASED <i>JOHN J. BROWN</i>		DATE OF DEATH <i>10/15/2003</i>	
AGE <i>78</i>		SEX <i>M</i>	
PLACE OF BIRTH <i>NEW YORK, N.Y.</i>		DATE OF BIRTH <i>10/15/1925</i>	
OCCUPATION <i>RETIRED</i>		CAUSE OF DEATH <i>HEART DISEASE</i>	
MANNER OF DEATH <i>NATURAL</i>		PLACE OF DEATH <i>HOME</i>	
SIGNATURE OF DECEASED <i>[Signature]</i>		SIGNATURE OF WITNESS <i>[Signature]</i>	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
DATE OF SIGNATURE <i>10/15/2003</i>		DATE OF SIGNATURE <i>10/15/2003</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
100 NORTH ST., 10TH FLOOR, BOSTON, MA 02109  
TEL: 617-725-6900 FAX: 617-725-6901  
WWW.DHS.MA.GOV